



State of California Division of Workers' Compensation

Public Records Act Request Form

If other than a routine request at a district office for viewing/copying file at the time of request, fax to: Stephanie Leach, Statewide Records Coordinator at (916) 322-3470

Date received _____

☐ Party/Representing a party

Due date _____

☐ Not a party

(Response Due: Immediately or within 10 days from date of request)

Requester Information [Voluntary unless seeking personal or individually identifiable information]

Name	
Company	
DWC Authorization Number [Copy, Legal & Investigative Services]	
Representing	
Business Address	
Alternative Address	
City, State, ZIP Code	
Telephone (business)	
Fax	
E-Mail	

Description of Records Requested/Initial Contact with Requesting Party:

☐ Inspection

☐ Copying

WCAB File No.:
Injured Workers Name:
Other:

Is Request for Purposes of Pre-Employment Screening?
(If yes, DWC shall send notification letter to injured worker)

☐ Yes ☐ No

For Requests for Personal Information or Individually Identifiable Information, state the purpose for which the information will be used and provide proof of identity and address.

Name of DWC Employee-Initial Contact: